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BACKGROUND DATA ON FISCAL YEAR 1987 SPENDING REDUCTION PROPOSALS UNDER JURISDICTION OF THE COMMITTEE ON FINANCE

Prepared by the Staff of the

COMMITTEE ON FINANCE

UNITED STATES SENATE

BOB PACKWOOD, *Chairman*

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PROPOSALS FOR PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE

[CBO estimates, outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1987	1988	1989	
A. MEDICARE:				
ADMINISTRATION BUDGET PROPOSALS AND ALTERNATIVES:				
1. Establish home health copayments	−95	−110	−125	−330
2. Freeze clinical laboratory fees	−48	−35	−35	−118
3. Delay initial eligibility date	−201	−295	−329	−825
4. Increase part B deductible	−254	−384	−479	−1,117
5. Establish voluntary vouchers	48	47	46	141
6. Extend Medicare as secondary payer	−256	−338	−372	−966
7. Apply cost-sharing to ambulatory surgery	−20	−39	−53	−112
8. Simplify processing of part A bills	−4	−4	−4	−12
9. Eliminate ESRD networks	−1	−1	−1	−3
10. Increase and modify part B premiums	−900	−2,000	−3,400	−6,300
11. Establish prospective payments for capital costs:				
a. Administration proposal	−390	−1,370	−1,860	−3,620
b. Alternative proposal	−70	−190	−340	−600
12. Modify direct medical education payments	−345	−450	−480	−1,275
13. Modify indirect medical education payments	−640	−770	−860	−2,270
14. Modify physician payments:				
a. Medicare Economic Index:				
1. Administration proposal	−120	−200	−250	−570
2. Alternative proposal	−50	−200	−250	−500
b. Inherent reasonableness	−98	−106	−120	−324
c. Stand-by anesthesia	−60	−61	−70	−191
15. Pre-authorize assistants at surgery	−12	−21	−26	−59
16. Modify ESRD rates:				
a. Administration proposal	−155	−165	−170	−490
b. Alternative proposal	−15	−15	−15	−45
17. Modify non-physician payments	−59	−75	−94	−228
18. Modify payments for return on equity	−6	−6	−6	−18
19. Revise waiver of liability process	−40	−80	−89	−209
20. Establish PPS rate of increase:				
a. Administration proposal (0.5%)	−490	−650	−720	−1,860
b. Alternative proposal (1.5%)	−180	−230	−260	−670
OTHER PROPOSALS:				
21. Modify hospital deductible calculation	270	420	330	1,020
22. Eliminate PIP for PPS providers and require timely claims payment	−2,880	−280	−320	−3,480
23. Reform ambulatory surgery payment	−45	−85	−120	−250
B. MEDICAID:				
ADMINISTRATION BUDGET PROPOSALS:				
1. Limit growth of Medicaid payments	−1,000	−1,529	−1,758	−4,287
2. Limit administrative costs	−260	−268	−278	−806
OTHER PROPOSALS:				
3. Expand eligibility for children and pregnant women	20	65	75	160
4. Expand eligibility for the elderly and disabled	38	192	240	470
5. Hold States harmless	50	0	0	50

PROPOSALS FOR PROGRAMS UNDER JURISDICTION OF THE FINANCE COMMITTEE—Continued

[CBO estimates, outlay effect in millions of dollars, net of offsets]

	Fiscal year—			Total
	1987	1988	1989	
C. CUSTOMS SERVICE:				
ADMINISTRATION BUDGET PROPOSAL:				
1. Impose user fees	−300	−295	−290	−885

A. MEDICARE

ADMINISTRATION BUDGET PROPOSALS AND ALTERNATIVES

1. Establish home health copayments

Current law.—Home health services are not subject to coinsurance charges.

Administration proposal.—The Administration proposes to establish a copayment equal to 1 percent of the inpatient hospital deductible (estimated at $5.72 in 1987) on all home health visits, except those (1) following an inpatient hospital or skilled nursing facility stay for the treated condition or related condition, or (2) visits provided after 100 visits in a calendar year. The Administration also proposes to institute additional medical review of the appropriateness of home health services.

Effective date.—January 1, 1987.

Outlay Effect [In millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−95	−110	−125	−330

2. Freeze clinical laboratory fees

Current law.—Payments for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed by either a physician or by a laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients. For the period beginning July 1, 1984, the rates under both schedules are to be established on a regional, statewide, or carrier service area basis. The fee schedules are adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Begin-

ning January 1, 1988, the fee schedule for tests performed by a physician or laboratory is to be established on a national basis. At the same time, payment for hospital laboratory services is slated to revert to cost-based reimbursement.

Administration proposal.—The Administration proposes to freeze the fee schedule amounts for clinical diagnostic laboratory services for 1 year.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−48	−35	−35	−118

3. Delay initial eligibility date

Current law.—Eligibility for Medicare begins on the first day of the month in which an individual reaches age 65.

Administration proposal.—The Administration proposes to begin eligibility for Medicare on the first day of the month following the individual's 65th birthday.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−201	−295	−329	−825

4. Increase and index part B deductible

Current law.—Enrollees in the Supplementary Medical Insurance (part B) portion of Medicare must pay the first $75 of covered expenses (known as the deductible) each year before benefits are paid. The amount of this deductible is fixed by law. When the program was first enacted, the deductible amount was set at $50. It was increased to $60 in 1972 and to $75 in 1982.

Administration proposal.—The Administration proposes to increase the part B deductible to $100 in 1987, and then index the deductible to the Medicare Economic Index beginning in 1988.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−254	−384	−479	−1,117

5. Establish a voluntary voucher program

Current law.—Medicare payments are generally made on behalf of beneficiaries to hospitals and other institutions who participate in the program or through payment arrangements to or on behalf of beneficiaries in the case of physician and other medical services. Medicare also permits payment under a risk-sharing contract to health maintenance organizations and competitive medical plans; these payments are equal to 95 percent of the adjusted average per capita cost (AAPCC) for Medicare enrollees.

Administration proposal.—The Administration proposes to establish a voluntary Medicare voucher program under which beneficiaries could elect coverage under a private health benefits plan rather than Medicare. Beginning in 1987, private plans that enroll a Medicare beneficiary would be paid premiums set at 95 percent of the Medicare AAPCC and, in exchange, would be required to provide benefits at least equivalent in value to current Medicare benefits.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	48	47	46	141

6. Extend Medicare as a secondary payer

Current law.—The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) required employers to offer their employees aged 65 through 69 the same group health plan offered to their employees under age 65. The Deficit Reduction Act of 1984 (DEFRA) extended the provision to beneficiaries covered under a working spouse's employer-based health plan when that spouse is under age 65. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) extended this provision to the working aged and spouses over age 69. Where the beneficiary elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the option to be covered only by Medicare.

Administration proposal.—The Administration proposes to extend the secondary payer provision to disabled beneficiaries who are also covered under their own or a working spouse's employer-based health plan. The provision would be enforced through the use of an excise tax on employers who do not comply.

Alternative proposal.—Enforce the provision through the use of civil monetary penalties, rather than an excise tax.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration and alternative proposals	−256	−338	−372	−966

7. Apply cost-sharing to ambulatory surgery

Current law.—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary of Health and Human Services (HHS). Payments are made on the basis of prospectively set rates as the "standard overhead amount."

HHS issued final regulations and an accompanying notice, August 5, 1982, identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures have not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services.

No beneficiary cost-sharing is required in connection with services provided in ambulatory surgical centers.

Administration proposal.—The Administration proposes to impose the standard part B coinsurance (20 percent) and deductible ($75) for ambulatory surgery services.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−20	−39	−53	−112

8. Simplify processing of part A bills

Current law.—The responsibility for collecting deductible and coinsurance amounts from beneficiaries in connection with stays in

two or more hospitals is currently assigned in the chronological order in which services are furnished.

Administration proposal.—The Administration proposes to assign responsibility in the order in which hospitals submit claims for Medicare payments. A hospital that provided services after another hospital but submitted its payment request first would be responsible for collecting the deductible and be credited with the first 60 days of coverage (for which no coinsurance is required).

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−4	−4	−4	−12

9. Eliminate end-stage renal disease networks

Current law.—The Secretary of Health and Human Services was required to establish network organizations to assure effective and efficient administration of the end-stage renal disease (ESRD) program. The network organizations are responsible for coordinating and evaluating ESRD services provided within assigned geographic areas.

Administration proposal.—The Administration proposes to eliminate the ESRD networks.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−1	−1	−1	−3

10. Increase and modify part B premiums

Current law.—Under the original Medicare law, beneficiary premiums paid for 50 percent of the cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the law limited the percentage increase in the part B premium to the percentage increase in Social Security cash benefits payments. By 1982, beneficiary premiums paid for less than 25 percent of program costs.

TEFRA, as amended by the Social Security Amendments of 1983 (P.L. 98–21), specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce pre-

mium income equal to 25 percent of program costs for elderly enrollees. Disabled enrollees pay the same premiums, though the per capita cost of services to these enrollees is higher. DEFRA extended this provision for 1986 and 1987. COBRA extended this provision through 1988. Beginning in 1989, the premium calculation reverts to the earlier method.

Administration proposal.—The administration proposes to establish separate premiums for individual beneficiaries and third-party payers. The percentage paid by individuals would be increased over the next 5 years. Beginning with calendar year 1987, the proportion of program costs covered by the premium would rise two percentage points per year so that the amount the beneficiary pays would increase from an estimated 25 percent of program costs to a rate equal to 35 percent of estimated program costs in 1991. For third-party payers that buy Medicare part B coverage on behalf of their beneficiaries (primarily States which pay the Medicare premium for their Medicaid beneficiaries), the premium would be set at 50 percent of costs beginning in 1987.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−900	−2,000	−3,400	−6,300

11. Establish prospective payments for capital costs

Current law.—P.L. 98-21 established a prospective payment system (PPS) for making payments to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Payments for operating costs are made on the basis of fixed rates per discharge. Hospital capital-related costs of inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from PPS and are reimbursed on a reasonable cost basis. This exclusion was to expire on October 1, 1986, but enactment of P.L. 99-349, the Urgent Supplemental Appropriations Act, extended the exclusion until October 1, 1987.

In addition, under prior law, if Congress did not enact legislation by October 1, 1986 to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under Section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure. P.L. 99-349 extended the deadline for congressional action to October 1, 1987.

Administration proposal.—The Administration proposes by regulation to include capital costs in the prospective payment system rates for inpatient hospital services beginning in FY 1987. After a

four-year transition that would end in 1990, a fixed payment that includes both capital and operating costs would be made for each Medicare discharge.

During the four-year phase-in period, a declining portion of a hospital's payment for capital costs would be based on a hospital's capital costs and an increasing portion would be based on a national rate per discharge.

Hospital data from 1983 cost reports would be used as a base for calculating the national urban and rural capital-related base amounts. Hospital data from 1986 cost reports would be used as a base for calculating the hospital-specific capital-related base amount. Payments each year would be based on the lower of the hospital's allowable actual capital costs or the base year amount trended forward by the capital marketbasket. The national payment amounts would be updated from 1983 to fiscal year 1986 by the appropriate capital marketbasket indexes. For fiscal year 1987 and thereafter, the national payment amounts would be updated by the PPS update factor. The hospital-specific base amounts would be updated by the capital marketbasket index throughout the transition period.

Effective date.—October 1, 1986.

Alternative proposal.—This proposal would fully integrate capital costs into the prospective payment system (PPS) after a 10-year transition period.

a. Transition

During the transition Medicare payments to hospitals for capital would consist of a blend between hospital-specific capital costs and a Federal average capital payment amount as shown below:

	Hospital-specific proportion (percent)	Federal proportion (percent)
Fiscal year:		
1987	95	5
1988	90	10
1989	85	15
1990	80	20
1991	70	30
1992	60	40
1993	50	50
1994	40	60
1995	30	70
1996	15	85
1997		100

The hospital-specific capital payment amount would be the Medicare portion of the allowable capital costs actually incurred by a given hospital during each year of the transition under existing Medicare reimbursement principles.

The Federal capital payment amount would be the national Medicare standardized average capital cost per discharge for hospitals eligible for PPS payment.

The Federal proportion of the national capital payment rate (as defined by the transition blend) would be added to the nonlabor-related standardized amount of the Federal portion of the PPS rate as calculated under the current PPS transition formula.

During the transition, the national standardized average capital payment rate would be adjusted by an appropriate capital market-basket inflation factor to be developed by the Secretary of HHS. For each year after 1986, the national standardized average capital payment would be adjusted by the PPS update factor.

For new hospitals, the Federal proportion of the national standardized average capital payment amount during the transition period would be equal to the proportion applicable to the first complete fiscal year during which the hospital is operational.

b. Base year and rebasing

The base year for calculating the national capital rate would be FY 1986. To correct for any distortion introduced by the update factor during the transition, the national payment amount would be rebased on actual capital costs incurred in the fifth and last years of the transition.

The national standardized average capital payment rate would be adjusted to:

1. Offset interest expense with interest income;
2. Reflect local construction costs associated with depreciation of physical plant; and
3. Reflect changes in the cost of capital.

Effective October 1, 1986, section 1122 of the Social Security Act would be repealed.

c. Outlier payments

The proposal establishes outlier payments for those hospitals with average Medicare capital costs per discharge in a given cost reporting period in excess of 200 percent of the national average standardized capital payment amount regardless of when the capital expense was legally obligated.

For hospitals that qualify Medicare would add to the national average standardized amount for each Medicare discharge an amount equal to 80 percent of the difference between 200 percent of the national average standardized capital payment amount (the threshold) and the hospital's actual Medicare capital costs per discharge in that cost reporting period. Hospitals would be paid the proportion of this sum as determined by the capital payment transition schedule.

The first year for which a hospital may receive an additional capital payment would be FY 1990 (the fourth year of the transition). A hospital may not receive additional capital payments for more than 5 cost reporting periods. The 5 cost reporting periods do not have to be consecutive.

No additional capital payments would be made to any hospital after FY 1998 (two years post transition). Hospitals, hence, would have a 9 year "window" in which to receive 5 outlier payments.

The national average standardized capital payment amount per discharge would be adjusted each year from FY 1990 to FY 1998 to the extent necessary to fully offset the additional capital payments anticipated to be made during the year under this provision (budget neutrality).

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−390	−1,370	−1,860	−3,620
Alternative proposal	−70	−190	−340	−600

12. Modify direct medical education payments

Current law.—Direct costs of approved graduate medical education programs (such as salaries of interns and residents and education expenses of interns and residents, allied health professionals, and nurses) are excluded from the prospective payment system (PPS) and have been paid on the basis of reasonable costs.

COBRA changed the way Medicare reimburses hospitals for the costs of approved graduate medical education programs (the training of interns and residents). Medicare payment limits are established on each hospital's average cost per resident and on the number of years of training provided to residents. Medicare will continue to reimburse hospitals on a cost basis for direct medical education costs associated with nursing and allied health training activities. COBRA also prohibited the Secretary, except as otherwise specifically authorized, from limiting the rate of increase on allowable costs of approved medical education activities, effective for hospital cost reporting periods beginning on or after July 1, 1985.

Administration proposal.—The Administration proposes by regulation to eliminate payments for the education expenses of interns and residents while continuing payments for their salaries. The proposal would establish hospital-specific limits on payments for intern and resident salaries. The proposal would also eliminate payments to hospitals for nursing and allied health training.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−345	−450	−480	−1,275

13. Modify the indirect medical education payment

Current law.—Additional payments are made to hospitals under Medicare's prospective payment system (PPS) for the additional patient care costs associated with the presence of approved medical education programs. These costs may be due to such factors as the ordering of additional tests by interns and residents. The additional payments have been computed by applying an education adjustment factor to the Federal portion of the hospital's diagnosis-related group (DRG) payments.

Prior to PPS, indirect medical education costs were measured according to an estimate of the relationship between the increase in a hospital's costs and the increase in the ratio of interns and residents. This education adjustment factor served as the basis of Medicare payments for indirect medical education costs under cost limits applied under Medicare's reimbursement method in effect before PPS. With the enactment of PPS, Congress doubled this adjustment factor. This doubled factor was equal to 11.59 percent for each 0.1 increase (above zero) in the ratio of a hospital's interns and residents to its beds.

COBRA reduces the indirect medical education adjustment factor to approximately 8.1 percent from May 1, 1986 to October 1, 1988, applied on a curvilinear basis (i.e., the payment would not necessarily increase in direct proportion to the ratio of interns and residents to bed size). The payment adjustment after October 1, 1988 (when the authority for additional payments to hospitals serving a disproportionate share of low-income patients ends) will be approximately 8.7 percent.

Administration proposal.—The Administration proposes to reduce by half the pre-COBRA (11.59 percent) indirect medical education adjustment factor.

Effective date.—Hospital cost reporting periods beginning on or after October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−640	−770	−860	−2,270

14. Modify physician payments

Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community.

DEFRA froze physician fees for the 15 month period July 1, 1984 through September 30, 1985. P.L. 99-107, as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for nonparticipating physicians.

a. Medicare Economic Index

Current law.—Before 1984, customary and prevailing charge fee screens (i.e. benchmarks against which individual charges are compared) were updated annually. The annual update in the prevailing charge screen has been limited by the Medicare Economic Index (MEI). This limit, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels.

Administration proposal.—The Administration proposes by regulation to revise the calculation of the MEI to account for an adjustment to the housing cost component, which the Administration believes to be historically overstated. The index would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach.

Effective date.—October 1, 1986.

Alternative proposal.—The alternative proposal would provide that the adjustment of the MEI, as proposed by the Administration, would be made in two stages with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The proposal would require the Secretary to utilize the rulemaking process for proposed changes in the methodology, basis, or elements of the MEI.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−120	−200	−250	−570
Alternative proposal	−50	−200	−250	−500

b. Inherent reasonableness

Current law.—COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" which are to be used for determining Medicare payments.

Administration proposal.—The Administration proposes by regulation to apply "inherent reasonableness" guidelines to selected physician procedures in order to reduce Medicare payments for

these services. HHS issued proposed rule-making on February 18, 1986, summarizing the conditions under which the Secretary could use the "inherent reasonableness" authority to establish either special methodologies or specific dollar limits when fees paid under current methods are determined to be inherently unreasonable.

Effective date.—October 1, 1986.

Alternative proposal.—The proposal would identify instances where inherent reasonableness limitations could be applied though use of the limitations would not be limited to the identified instances. If the Secretary applies the inherent reasonableness authority the proposal specifies the factors that shall be considered in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reductions in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers, or there may be changes in the accessibility of and beneficiary liability for the service.

The proposal would provide that regional differences in fees would be taken into account unless there is substantial economic justification for a uniform national fee or payment limit. The Secretary would be required to use the rule-making process in any case where he or she proposes to establish a new reasonable charge, or a methodology for a new reasonable charge, based on inherent reasonableness determinations. The proposal would require a public comment period and comments by the Physician Payment Review Commission. The proposal would require final regulations to explain the factors and the data the Secretary considered in making the final determinations. The proposal would require the Secretary both to develop an index for adjusting relative value scale (RVS) payment levels to reflect justifiable geographic cost differences and to examine a possible adjustment to encourage physicians to locate in medically underserved areas. The proposal would require the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandate its use for hospital outpatient services.

Effective date.—Applies to final regulations issued after April 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration and alternative proposals	−98	−106	−120	−324

c. Stand-by anesthesia

Current law.—Medicare uses the same payment methodology for anesthesia services whether the anesthesiologist administers general anesthesia or stands by and monitors the general care of the patient while the surgeon performs local anesthesia.

Administration proposal.—The Administration proposes by regulation to limit payments to physicians who either provide standby anesthesia services or administer no anesthesia.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−60	−61	−70	−191

15. Pre-authorize assistants-at-surgery

Current law.—COBRA mandates prior authorization in order for payment to be made for assistants-at-surgery for cataract procedures. COBRA also requires the Secretary to report to Congress by January 1, 1987 on other procedures for which such prior approval for assistants at surgery should be required.

Administration proposal.—The Administration proposes by carrier manual instructions to implement pre-payment review for the medical necessity of assistants-at-surgery. (This instruction was implemented January 1, 1986 for cataract surgery).

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−12	−21	−26	−59

16. Modify end-stage renal disease rates

Current law.—Medicare makes both a facility and a physician payment under the end-stage renal disease (ESRD) program for routine dialysis performed on an outpatient basis. Effective August 1, 1983, payment for outpatient dialysis has been made on a prospective basis. For routine dialysis services, the supervisory physician receives a monthly capitation rate and the facility receives a per-treatment facility rate.

Administration proposal.—The Administration has published proposed regulations in the Federal Register to revise the calcula-

tion of ESRD payments. Physician payments would be reduced to reflect a recent General Accounting Office (GAO) study on the frequency of physician visits for home dialysis patients as compared to physician services received by facility patients. Facility rates also would be reduced to reflect the most recently audited cost data for home and in-facility dialysis and a change in the composite rate formula which weights costs by the number of treatments rather than by the number of facilities.

Effective date.—August 1, 1986.

Alternative proposal.—This proposal would reduce physician payments based on the GAO study.

Effective date.—August 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−155	−165	−170	−490
Alternative proposal	−15	−15	−15	−45

17. Modify non-physician payments

Current law.—Payments for durable medical equipment and certain other services and supplies are made on a reasonable charge basis under part B.

Administration proposal.—The Administration proposes by regulation to review reasonable charge levels and revise payments to reduce charges for non-physician services (primarily durable medical equipment) paid for on a reasonable charge basis under part B, that are determined to be excessive.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−59	−75	−94	−228

18. Modify payments for return on equity

Current law.—Return on equity (ROE) capital invested and used in providing patient care is a Medicare allowable cost for proprietary (for-profit) health care providers. Equity capital is the net worth of a hospital or other health facility excluding those assets and liabilities not specifically related to patient care.

The level of payment for ROE for inpatient hospital services was reduced by P.L. 98–21 from 150 percent to 100 percent of the rate of return on assets of the Hospital Insurance Trust Fund. The rate of return for other provider services remained at the higher rate.

COBRA phases out ROE for hospitals over a three-year period. The legislation also reduced the rate of payment for ROE for skilled nursing facilities to 100 percent of the rate of return on assets of the Hospital Insurance Trust Fund, and required that if the Secretary acts to pay for ROE for any other type of non-inpatient provider, the rate of payment must also equal 100 percent of the rate of return on trust fund assets.

Administration proposal.—The Administration proposes by regulation to eliminate the allowances for ROE for all proprietary providers other than skilled nursing facilities and hospitals, primarily home health providers.

Effective date.—August 1, 1986.

Outlay Effects [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−6	−6	−6	−18

19. Revise waiver of liability process

Current law.—Payment may be made to an institutional provider for certain uncovered or medically unnecessary services, if the provider could not have known that payment would be disallowed for these services. Hospitals, skilled nursing facilities, and home health agencies participating in Medicare have been presumed to have acted in good faith (and therefore may receive payment for services later found to be uncovered or unnecessary) if their total denial rate on Medicare claims is lower than prescribed levels.

HHS issued regulations on February 21, 1986 which would end the favorable presumption status. However, COBRA maintained the favorable presumption criteria for home health agencies and skilled nursing facilities for specified time periods. COBRA does not maintain the favorable presumption for hospitals.

Administration proposal.—The Administration proposes by regulation to repeal the favorable presumption of non-liability for providers so that reimbursement would not be allowed for any uncovered or medically unnecessary services. A similar waiver of liability provision for beneficiary cost-sharing liability would be retained.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−80	−89	−98	−267

20. Establish PPS rate of increase

Current law.—The Social Security Amendments of 1983 (P.L. 98-21) authorized the Secretary of Health and Human Services (HHS) to determine the rate of increase in the PPS rates for FY 1986 and thereafter, taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC). DEFRA limited the FY 1986 rate of increase to be determined by the Secretary to the rate of increase in the marketbasket plus one-quarter of one percentage point. HHS issued final rules on September 3, 1985 freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of the Emergency Extension Act of 1985 (P.L. 99-107, as amended by P.L. 99-201), which provided that from October 1, 1985 through March 14, 1986, the FY 1986 PPS rates would be frozen at FY 1985 levels.

COBRA provided that the FY 1986 rate freeze continue until May 1, 1986, when the PPS rates would be increased one-half percent for the remainder of the year. In addition, for FY 1987 and FY 1988, it provided that the Secretary could determine any change in the PPS payment rates, taking into account the recommendations of the ProPAC, not to exceed the marketbasket index change. The rate of increase for PPS-exempt hospitals was 5/24 of one percent, effective for hospital cost reporting periods beginning October 1, 1985, but before October 1, 1986. The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by one percent beginning March 1, 1986.

Administration proposal.—The Administration's FY 1987 budget assumed an increase in the FY 1987 PPS payment rates of 2 percent. In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and the rate of increase for PPS-exempt hospitals. In its July 2, 1986 report to HCFA, ProPAC recommended that the FY 1987 PPS rates be increased by 2.2 percent, the rate of increase for children's hospitals be 3.2 percent, and the rate of increase in PPS-exempt hospitals and units be 3.5 percent.

Alternative proposal.—Provide an increase in the payment rates for PPS hospitals and PPS-exempt hospitals in FY 1987, other than that proposed by the Administration.

Effective date.— October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal (0.5%)	−490	−650	−720	−1,860
Alternative proposal (1.5%)	−180	−230	−260	−670
(1.8%)	−70	−90	−100	−260

OTHER PROPOSALS

21. Modify hospital deductible calculation

Current law.—Medicare's inpatient hospital deductible must, by law, be increased each January. The deductible is increased based on a formula which reflects the average cost of a day of hospital care.

Because lengths of stay have been decreasing faster in recent years than costs per stay (partially because of the implementation of the prospective payment system), total costs are now divided by a smaller denominator; this results in a higher per-day figure. The deductible was $400 in 1985, and is $492 in 1986. The Administration estimates that the deductible will increase by 16 percent to $572 in 1987.

Proposal.—The proposal would set the deductible at a special amount for 1987 and then tie the increase in the deductible to the average cost of a Medicare hospital admission instead of the average cost of a hospital day.

Effective date.—January 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Proposal ($520 deductible in 1987)	440	690	660	1,790
($540 deductible in 1987)	270	420	330	1,020

Note: These estimates are based on a 2 percent increase in hospital payment rates.

22. Eliminate PIP for PPS providers and require timely claims payment

Current law.—Hospitals, skilled nursing facilities and home health agencies who meet certain requirements may receive Medicare periodic interim payments (PIP) every two weeks based on estimated annual costs attributed to estimated Medicare utilization of the provider, without regard to the submission of individual bills. At the end of the year, a settlement is made so that the provider receives the actual payment amounts for treating Medicare

beneficiaries. In proposed fiscal year 1987 regulations for the prospective payment system (PPS), the Department of Health and Human Services proposed to end PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987, except in the event a beneficiary is an inpatient for more than 45 Medicare-covered days.

The Health Care Financing Administration (HCFA) recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers of health care.

Proposal.—This proposal would eliminate periodic interim payments for PPS hospitals. PIP would be retained for non-PPS hospital inpatient services, skilled nursing facility inpatient services, and home health agency services. In addition, this proposal would require each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 21 days of receipt. The elimination of PIP for PPS hospitals would be delayed until an intermediary had demonstrated that it had complied with the prompt payment provision for at least two consecutive quarters. The Secretary would be required to establish, on a temporary basis, interim payments during any period in which claims processing is suspended.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Proposal	−2,880	−280	−320	−3,480

23. Reform ambulatory surgery payment

Current law.—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary of Health and Human Services (HHS). Payments are made on the basis of prospectively set rates as the "standard overhead amounts."

HHS issued final regulations and an accompanying notice. August 5, 1982, identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures has not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services.

No beneficiary cost-sharing is required in connection with services provided in ambulatory surgical centers.

Proposal.—This proposal would extend the ambulatory surgical center (ASC) prospective payment approach to hospital outpatient department (OPD) surgery. For all surgeries approved for performance in an ASC, Medicare-participating hospitals would receive the lesser of (a) Medicare's reasonable costs for surgery minus 20 percent of the actual charge, OR (b) Medicare's prospective rate for ASC's minus 20 percent of that rate. The provision would be effective for hospital accounting years that begin on or after July 1, 1987.

No later than July 1, 1987, the Secretary would be required to update the 1982 ASC rates that are currently in use. Thereafter, the Secretary would annually review the ASC and OPD rates and revise the list of procedures which are approved for ASC performance and reimbursement.

Effective July 1, 1987, hospitals will be required to use HCFA's Common Procedures Coding System (HCPCS) for all Medicare Part B services and items provided in hospital outpatient departments, and the waiver of cost sharing for ASC facility fees would be repealed. Utilizing the OPD HCPCS data that will be available after July 1, 1987, the Secretary will be required to: (1) develop packages of pre- and post-operative services for different procedures that are appropriate for application of a prospective payment system, and (2) develop a PPS methodology for all outpatient procedures. The Secretary is to report to Congress on these packages and the PPS methodology by January 1, 1991.

For 1988, the Secretary would be required to add to each utilization and quality control peer review organization (PRO) scope of work the requirement that PROs review the medical necessity and quality of surgery in OPD and ASC settings. The percentage of cases to be reviewed, and whether there is to be pre-and post-procedure review, is left to the Secretary's discretion. There is one exception to this provision: PROs are to conduct 100 percent pre-procedure review of all cataract surgeries which are performed on or after January 1, 1987. Payments for the cost of certified registered nurse anesthetist (CRNA) services and direct medical education would continue to be made as under current law. The Secretary would be required to conduct a two-year study on educational activities in hospital outpatient settings and report back to Congress with recommendations about a proper graduate medical education (GME) component for OPDs.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal years—			Total
	1987	1988	1989	
Proposal	−45	−85	−120	−250

B. Medicaid

ADMINISTRATION BUDGET PROPOSALS

1. Limit growth of Medicaid payments

Current law.—The Federal government shares with the States the costs of Medicaid services through a variable matching formula. The formula has been adjusted every two years. Under COBRA the formula is updated each year, beginning in fiscal year 1987. The matching rate ranges from 50 percent to 78.42 percent.

Administration proposal.—The Administration proposes to limit Federal Medicaid expenditures for medical services to $23.6 billion in fiscal year 1987. This limit represents a $1 billion reduction in Federal payments below current fiscal year 1987 spending projections contained in the Administration's fiscal year 1987 Budget. The $1 billion figure takes into account regulatory proposals to limit prescription drug reimbursement and to require second surgical opinion programs. The figure also takes into account the costs attributable to the one-time $300 million "hardship pool". Federal payments to States would continue to match State expenditures but only up to each State's individual limit. Federal spending increases in future years would be tied to the medical care component of the Consumer Price Index. States would be given greater flexibility to design and operate their Medicaid programs.

The Administration proposes to establish a one-time $300 million "hardship pool" in fiscal year 1987. These funds would be used to assist States with costs over their limit.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−1,000	−1,529	−1,758	−4,287

2. Limit administrative costs

Current law.—Medicaid law specifies a Federal matching rate of 50 percent for administrative costs with the following exceptions: professional medical personnel used in program administration (75 percent), automated claims processing systems (90 percent for development, 75 percent for operation), family planning administration (90 percent), establishment and operation of State fraud and abuse control units (90 percent for the first 3 years, 75 percent thereafter), and review activities conducted by peer review organizations under contracts (75 percent).

Administration proposal.—The Administration proposes to eliminate all special administrative matching rates. These activities would all be matched at the regular 50 percent rate.

The Administration proposes to reduce the matching rate for States with per recipient administrative expenditures over 175 percent of the national median. The matching rate would be reduced from 50 percent to 25 percent for those costs which exceed the 175 percent limit.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−260	−268	−278	−806

OTHER PROPOSALS

3. Expand eligibility for children and pregnant women

Current law.—States are required to provide Medicaid coverage to all children receiving assistance under the Federally-assisted Aid to Families with Dependent Children (AFDC) program and may provide coverage for children who would be eligible for AFDC except for income requirements (known as the medically needy). In addition, States may cover all or reasonable categories of children under age 18 or 19 or 20 or 21 who do not meet the AFDC definition of dependent child (known as Ribicoff children). States are required to cover all children born after October 1, 1983 up to age five who meet the AFDC income and resources requirements and may extend coverage to all such children under age five immediately. States are also required to cover pregnant women meeting AFDC income and resources standards. The January 1986 AFDC levels in the 48 contiguous States and the District of Columbia were all below the poverty line.

Proposal.—The States would have the option to expand Medicaid eligibility to cover (1) pregnant women with an income threshold above the State's AFDC level up to 100 percent of the Federal poverty level, and (2) children up to age one with family incomes above the State's AFDC level up to 100 percent of the Federal poverty level. The resource limit is eliminated completely for pregnant women, and for children may not be more restrictive than the AFDC resource standards. The election of this expanded coverage would be optional for the States and would include prenatal, delivery, and 60-days of post-partum care services for the women and all Medicaid services for children for their first year.

Effective date.—April 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Proposal	20	65	75	160

4. Expand eligibility for the elderly and disabled

Current law.—Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses. The income and resources eligibility criteria differ substantially among the States.

Proposal.—The States would have the option to expand Medicaid eligibility to cover the elderly and disabled with an income threshold up to 100 percent of the Federal poverty level for (1) all Medicaid services; or (2) only the cost of the Medicare part A deductible and coinsurance, and the part B premium, deductible, and coinsurance. The resource limit would be the same as under the SSI program for those whose eligibility is related to cash programs, but could be higher for those whose eligibility is related to medically needy rules. The election of this expanded coverage would be optional for the States, but the election could only be made where the State also provides coverage to pregnant women and children up to age one and limits the income threshold for the elderly and disabled individuals to that established for the pregnant women and children up to age one.

Effective date.—July 1, 1987.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Proposal	38	192	240	470

Note: Preliminary estimate.

5. Hold States harmless

Current law.—COBRA provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP, which represents the Federal share of Medicaid expenditures in the State, is tied to a formula inversely related to the per capita income of the State.

Proposal.—Any State Medicaid program adversely affected by the Federal Medical Assistance Percentage (FMAP) annual calculation as required by COBRA would be permitted to continue to use the FY 1986 match rate for FY 1987 instead of the new lower match rate that would have applied.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Proposal	50	0	0	50

C. Customs Service

ADMINISTRATION BUDGET PROPOSAL

1. Impose user fees

Current law.—The Customs Service has had authority for many years to seek reimbursement for its costs in limited circumstances, such as for overtime for customs inspectors. Under COBRA a schedule of Customs user fees was authorized for the entry of commercial vessels and trucks, railroad cars, private aircraft and boats, passengers arriving on commercial vessels or aircraft from other than Canada, Mexico, Insular possessions and adjacent islands, dutiable mail, and for the issuance of Customs broker permits. These fees are expected to reduce spending by $220 million in FY 1987.

Administration proposal.—The Administration proposes to impose user fees on merchandise entries which would reduce spending by $300 million in FY 1987 in addition to the spending reductions pursuant to existing user fees.

Effective date.—October 1, 1986.

Outlay Effect [in millions of dollars]

	Fiscal year—			Total
	1987	1988	1989	
Administration proposal	−300	−295	−290	−885

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